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The Credibility of Nursing Evidence: Three Case Studies Demonstrating the Devaluing of Nursing Knowledge and Experience to Serve the Hegemonies of Power and New Public Management

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The voice of nursing has struggled to be heard in matters relating to patient safety, quality of care, and the health and wellbeing of patients and communities. In Aotearoa New Zealand we have entered a period of intense fiscal scrutiny and austerity, where nursing (as the largest healthcare workforce) is being expected to save money through budget cuts, freezing of positions, and limited career progression to advanced nursing roles. Using institutional ethnography as the approach to explicate how managerial practices are imposed and operate in the healthcare sector, we present three case studies of extant highly political issues, which directly affect patient safety: 1) Registered nurse safe staffing in hospitals; 2) The overdue transformation of primary healthcare; and 3) The education and training of nurse practitioners (NPs). Each case study highlights how nursing knowledge and evidence is being excluded from the frontline, the design of services, and from policy and budgeting tables. We identify how hegemonic discourses and practices (neoliberal, new public management and medicine) subordinate the credibility of nursing knowledge and relegate it to a lower position in knowledge hierarchies, in turn posing a risk to patient safety. The paper raises epistemological issues related to whose knowledge is valuable, who is considered to know best, and whose interests are served when certain epistemologies are valued over others.

Te reo Māori translation

Ngā Tapuhi Rēhita i roto i ngā Kaupapa Here: Te noho i waenga pū i te mahi whaiaro me te mahi kirimana

Ngā Ariā Matua

Kāore i tino rangona te reo o ngā tapuhi mō ngā āhuatanga e pā ana ki te haumarū tūroto, te kōunga taurimatanga, te hauora me te toiora o ngā tūroto me ngā hapori. I Aotearoa nei, kua tomo tātou ki tētahi wā arotake, here whakapaunga nui, i roto i ngā tūmanako kia whakaheke ngā utu e ao tapuhi (ko te ao tapuhi te kāhui kaimahi hauora nui rawa), i roto i te hiahia kia whāomoomotia he moni mā te tapahi rārangi pūtea, te whakatoka i ngā tūranga, me te whakauaua i te pikinga ara mahi ki ngā tūranga tapuhi teitei. Nā te whakamahi i te mātauranga momo tangata ā-hinonga hei ara mō te whakamārama i ngā tikanga whakahaere i whakatauria, e whakamahia ana hoki i te rāngai hauora, tēnei mātou te tāpae atu nei i ētahi mātainga e toru o ētahi take tōrangapū rawa o te wā, ka pā tika nei ki te haumarū tūroto: 1) Ngā taumata kaimahi tapuhi i roto i ngā hōhipera; 2) Te whakaumutanga o te taurimatanga hauora taketake kua roa e tāria nei; me te 3) akoranga me te whakangungu mō ngā kaimahi tapuhi (ngā NP). Ka kitea i roto i ia tū āhua he pēhea ngā mātauranga me ngā taunakitanga tapuhi i

wehea ai i te aroākapa o ngā mahi, te hoahoatanga o ngā ratonga, me ngā tēpu wānanga kaupapa here, whakatakoto pūtea hoki. Ka tautohu mātou he pēhea ngā kōrero angahao herekore i ētahi atu, me ngā mahi anō hoki (tuku noa i ngā mahi pakihi, ngā kaiwhakahaere hauora tūmatanui me te ao rongoā hou) e tāmi ai i te mōhiotanga o te ao tapuhi, e whakahokia ai ki tētahi taumata pāpaku i roto i ngā whakapaparanga mōhiotanga, me te puta mai o ētahi tūraru mō te haumaruru tūro. I tēnei pepa ka whakatairangatia ētahi take mātauranga e pā ana ki te pātai ko te tohunga whai mōhiotanga whai hua, ko wai kei te tino mōhio, ko wai hoki te hunga ka whiwhi painga, ki te whakapikia ētahi tikanga wehewehe mātauranga ki runga ake i ētahi.

Ngā kupu matua

Anga mātauranga; mātauranga momo tangata; nurse practitioners / mātauranga tapuhi, mahi tapuhi, haumarutanga tūro; kaupapa here; tōrangapū; taurimatanga hauora; taumata kaimahi haumaruru

INTRODUCTION

Historically, the voice of nursing has struggled to be heard in matters relating to patient safety, quality of care, and the health and wellbeing of patients and communities. While nursing has driven social justice agendas to improve access to health services, particularly to address health disparities (Rudner, 2021; Walter, 2017), their power to enact change across health systems has been consistently marginalised (Carrier, 2022; Dillard-Wright & Shields-Haas, 2021). In terms of credibility, nursing's knowledge claims are constructed in similar ways to other sciences (Sertler, 2022). However, inequitable power structures and contested professional terrain contribute to pervasive and unjustified exclusions (Cash, 1997; Sertler, 2022) of nursing knowledge at the frontline, from the design of services, and from policy and budgeting tables. This was never clearer than through the COVID-19 pandemic where, despite media and public acknowledgement of the value of nurses on the frontline, nursing's voice and perspectives were rarely present in local and national decision-making (McDonald, 2022; Popoola, 2021; Rasmussen et al., 2022). While society grants 'authority' to knowledge and expertise (generally, but not exclusively, based on the duration of training) the authority given to nurses and their work is a reflection of their status, which is both gendered and subordinated (Cash, 1997; Toole, 2019). Health policy decisions remain dominated by politicians, bureaucrats, and medical professionals (Adams & Carrier, 2021; McDonald, 2022).

In this paper we present three case studies of health service and workforce related issues, which capture the consistent and repetitive failure to heed nursing's professional guidance and presentation of evidence on matters directly related to nursing. We write as four doctorally prepared nurse leaders with diverse backgrounds and experiences in health service leadership and academic engagement. We present three case studies, drawing on institutional

ethnography (IE). These arise from the doctoral work of RM (McKelvie, 2019)¹ and RW (Webster, 2022)², and post-doctoral research³ of SA, building from her doctoral thesis (Adams, 2017)⁴, and all supervised by JC. Here we revisit their relevancy to significant challenges facing the Aotearoa New Zealand health sector in 2024: 1) Registered nurse safe staffing in hospitals; 2) The overdue transformation of primary healthcare; and 3) The education and training of nurse practitioners (NPs). At a higher level, the case studies also demonstrate hegemonic assumptions about who and what is accorded value or relevance when designing and shaping health policy. The paper raises epistemological issues related to whose knowledge is valuable, who is considered to know best, and whose interests are served when certain epistemologies are valued over others.

BACKGROUND

Since the 1980s, the health sector in Aotearoa New Zealand has operated within a neoliberal policy environment, supported by principles of new public management, which emphasise general managerialism and the application of business models (P. Barnett & Bagshaw, 2020; Gauld, 2016). Neoliberalism has been critiqued for widening the health disparity gap by increasing socio-economic hardship and reducing the right to health (P. Barnett & Bagshaw, 2020; MacNaughton & Ahmed, 2023).

While the early 2000s saw some retreat from neoliberalism in Aotearoa New Zealand and a move towards more social democratic policies, such as the Primary Health Care Strategy (King, 2001), there was growing concern about the health sector's ability to deliver on universality and equity (P. Barnett & Bagshaw, 2020; Gauld, 2016; Goodyear-Smith & Ashton, 2019). The Health and Disability System Review (HDSR) (2020) identified a system under serious stress, often fragmented, geographically variable, and with significant barriers to delivering accessible and equitable health-

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2 Ethics approval Massey University Human Ethics Committee: Southern A, Application 16/63

3 Ethics approval University of Auckland, AHREC Application AH21900

4 Ethics approval Massey University Human Ethics Committee: Northern, Application 12/062

care for Māori, as well as other underserved and prioritised groups. Further, the Waitangi Tribunal (2019) highlighted the multiple breaches of Te Tiriti o Waitangi in the health sector resulting in persisting poorer health outcomes for Māori (Came et al., 2020). The health reform legislation through the Pae Ora (Healthy Futures) Act (2022), signalled a move towards more socially just and equity-based policies.

However, the incumbent coalition government (formed in November 2023) has again shifted the ideological political landscape, returning to right of centre political ideology, revitalising neoliberal policy and new public management systems and processes to manage the health sector through managerial accountabilities (Löfgren et al., 2022; E. Stewart & Smith, 2015). Managerialism is concerned with measurable, short-term key indicators, rather than innovative longer-term solutions (Freeman & Baum, 2024). *Wasteful spending* and a *culture of fiscal discipline*, including significant public sector workforce cuts, have fore-fronted the drive to cost-effectiveness and value-for-money (Luxon, 2024; New Zealand Herald, 2024). Particularly, there is concern over the tranche of recommendations to repeal or amend legislation, which is anticipated to further breach Te Tiriti o Waitangi and have a deleterious impact on Māori, perpetuating inequities (Pitama et al., 2024). There is an imperative for nursing to strongly stand together to raise the voice of nurses promoting social justice.

INSTITUTIONAL ETHNOGRAPHY

Institutional ethnography (IE) was developed by Dorothy Smith (1999, 2005) to challenge patriarchal knowledge systems and make visible how people's local experiences and practices were being subjugated and discounted. All three doctoral projects used Smith's IE to research from within the social complex of everyday life and work to explore and explicate how people's everyday activities and experiences are coordinated and organised within an institution. Institutions are formed around a distinct function, such as healthcare, and are embedded in the ruling relations (Smith, 2005). The ruling relations are a "complex regime of institutions and governance" (Rankin, 2017, p. 2) and are produced by "those institutions of administration, management, and professional authority, and of intellectual and cultural discourses, which organise, regulate, lead, and direct contemporary capitalist societies" (Smith, 1990, p. 2). Ruling is achieved textually through a variety of mechanisms replicated throughout the institution, including textual chains (for example, written policies, procedures, memos), institutional processes (such as meetings, reporting systems and IT management systems), and professional and societal discourse (Smith, 2006). One key value of IE, as a research approach in health, is the ability to reveal how institutions are themselves organised and in turn organise the work and everyday actions of employees and patients.

An IE begins from the experiences and actualities of a particular group (the standpoint group) and how they participate in the everyday (and often invisible) social and ruling relations of the institution (Cupit et al., 2021). The

research intends to find traces of the institutional ruling relations from descriptions of the actual work and activities of people – in our case nurses, NPs, patients – from their standpoint location in the local setting (Rankin, 2017). The entry point to further analysis is through experiences identified as conflicts, tensions, or disjunctures (Cupit et al., 2021; Smith, 2005). The goal is then to empirically map how the coordination and ruling is being achieved textually in those local settings by the institution (Turner, 2006). The experiences of people in unconnected local situations are likely similar because of the power of the ruling relations that operate to organise everyday lives across institutions and systems (M. Campbell & Gregor, 2004).

The material and tangible ways of how institutional and hegemonic priorities are inserted into everyday knowledge and work when traced, show how often contradictory interests are activated or subordinated (M. Campbell & Gregor, 2004; Rankin, 2017). For example, institutional technologies (such as electronic forms and records) are intended by general managers to improve efficiency and cost-effectiveness. However, institutional ethnographies reveal how the knowledge of nurses on the ground floor are discounted, constraining nurses' autonomy and moral agency through these managerial processes, such as surgical safety checklists (Facey et al., 2024); bar-coded medication administration (Boonen et al., 2020); nurses' feeding practices with neonates (Ringham et al., 2020); and quality of care and wait times in the emergency department (Melon et al., 2013). Griffith and Smith (2014) describe how, in the era of new public management and under a neoliberal policy framework, IEs have been particularly valuable in "discovering how new managerial practices have been imposed and operate in public sector services" (p. 7).

The position of the researcher is important for readers to understand. Smith's IE, as a sociology for people (Smith, 2005), is inherently political, rooted in activism with the aim of promoting social justice (Kearney et al., 2019). The coordinating power of the ruling relations results in people, often unwittingly, participating in the institutional regime of ruling, where dominance and privilege are held (Smith, 2005). An IE researcher works in and from the interests of a particular standpoint group, who are in some way marginalised, oppressed, or subordinated, to show how experiences are organised by common and repeated ruling institutional processes (M. Campbell & Gregor, 2004; Cupit et al., 2021). The researcher explicitly and knowingly is "taking sides" (Cupit et al., 2021, p. 22), to show the institutional forces that shape what happens in the standpoint setting, providing the opportunity to disrupt and transform aspects of the institution. As identified by Solomon (2023), researchers who use IE find that mapping the social and institutional relations becomes embedded as part of their everyday thinking and work, extending beyond specific research projects. We present three case studies, using the tools of IE to extend the visibility granted through our original doctoral projects, and re-examine the concerns within the current context of governing and institutional ruling.

THREE CASE STUDIES

Case study one: Registered nurse staffing in hospitals

McKelvie's (2019) IE doctoral research interrogated unresolved nurse staffing in New Zealand hospitals, despite a decade of nationwide staffing strategies and ongoing challenges to recruit and retain nurses. During McKelvie's research, the Safe Staffing Accord (New Zealand Nurses Organisation, 2018) came into effect, mandated by the (then) government, identifying the Care Capacity Demand Management (CCDM) programme as the staffing solution for Aotearoa New Zealand. Millions of dollars were spent on patient acuity systems and staffing calculations with some gains made; but frontline nurses continued to report that staffing issues were unresolved. Five years following the publication of McKelvie's thesis, the context of safe staffing has again shifted. The nursing vacancies' crisis has been temporarily relieved by the immigration of internationally qualified nurses (IQNs); indeed hundreds of IQNs are without jobs (Blessen, 2024); yet the challenges of achieving safe staffing remain within a health sector focussed on new managerial accountability regimes, within a political climate of funding constraints and public sector reforms.

The COVID-19 pandemic and its aftermath resulted in a nursing workforce crisis worse than before. Aotearoa New Zealand's heavy reliance on internationally qualified nurses (IQNs) was magnified by closed borders (Clubb, 2022). Reactive strategies following the pandemic included immigration changes and incentives to facilitate a significant increase in IQN numbers. As of September 2024, the percentage of IQNs with Annual Practising Certificates in the nursing workforce had risen from 27% in 2020 to 46.3% (Chalmers, 2020; Nursing Council of New Zealand [NCNZ], 2024). Concurrently, extensive health sector reforms under the Pae Ora (Healthy Futures) Act (2022) and its six key strategies (Ministry of Health, 2023) were followed by a change of government with resultant changes in political ideology and social policy.

The arrival of nearly 15,000 IQNs in the past 12 months (NCNZ, 2024), while much needed to fill vacancies across the sector, is not a quick fix. To mitigate a short-term, ill-conceived solution grounded in general managerial principles, nursing leadership must now provide blended workforce integration programmes to ensure the new workforce not only are able to function well as RNs and deliver culturally safe and effective care but are themselves cared for and respected within our health system and society. Yet, the "success" of filling vacancies with IQNs has further backfired on nursing with health bureaucrats now claiming the recruitment drive as significantly responsible for the sector's deficits and ensuing cuts (Daalder, 2024). The importance of *growing our own* nursing workforce and retaining the nurses we have, whether New Zealand or overseas trained, is critical for the future stability of the nursing workforce and consequent healthcare of the population.

However, in June 2024, a matter of days out from the nursing student's final state exams, an intent to freeze domestic nursing graduates' employment within hospitals

due to fiscal constraints, became public knowledge (New Zealand Nurses Organisation [NZNO], 2024). Neither NZNO nor the College of Nurses Aotearoa (New Zealand), nor academics in the tertiary sector, nor indeed executive nurses in the employer organisations, were consulted on the impact and implications of this course of action, which appears unfathomable. Fepulea'i Margie Apa, chief executive of Health New Zealand, reported that not having enough places for graduate nurses in hospitals was "a great problem to have" (Collins, 2024 para 1), signalling a commitment to managerial public sector reforms led by organisational professionals (strategic bureaucrats) (Löfgren et al., 2022). The deep and extensive professional and contextual intelligence of nursing's leaders, on matters of national importance concerning the nation's health, was not sought. The ripple effects of not valuing domestic nursing students may fundamentally undermine recruitment of future students, with particular consequences to addressing issues of equity.

McKelvie's (2019), doctoral research on the Nurse Safe Staffing Project, including the government endorsed nurse staffing solution, the CCDM programme, is (at present) the only whole of programme investigation traversing the entire research terrain from frontline experience of nurses to central government policy and global ideology on patient safety and nursing workforce shortages. The research produced a meticulous charting and rigorous iterative analysis of the frontline nurses' experiences and the everyday operation of staffing project tools in New Zealand hospitals. Despite the staffing project strategies being built by nurses using frontline contextual knowledge and an extensive body of nurse-led research, the analysis illuminated how nurse staffing knowledge, research and strategies are subject to the competing institutional priorities dominating health-care institutions. The influence of these dominant priorities (such as cost efficiencies, value-for-money, organisational and health targets) manifests in ways that re-package nuanced knowledge and practice into standardised quantifiable units and processes. These ruling textual processes cloud and subordinate actual nursing knowledge as a source of evidence for staffing decision-making (McKelvie, 2019).

Nurses know whether or not there are enough nurses with the right skills, knowledge, and experience for the needs of the patients in front of them, and whether the resourcing of the care environment sets them up to succeed in the delivery of nursing care. Additionally, the nursing team's knowledge of each patient is understood in the context of current needs, in the moment-to-moment of care; anticipated needs, as things change with condition and treatment; and unexpected needs, in response to sudden dynamic changes in patient condition. The crucial and highly skilled gathering, interpreting, analysing, and acting on all of this knowledge in continuously changing circumstances and in any given care context, McKelvie (2019) calls *situated intelligence*. Situated intelligence would be the best and most effective knowledge for designing and operating nurse staffing strategies, but that is not what McKelvie's investigation has revealed.

For close to 30 years, nurses have been raising their concerns about patient safety, avoidable harm to patients and staff, and the challenges, risks and sacrifices of chronically eroded staffing and working conditions. Nurses' testimonies of concern have prompted industrial action as well as extensive research worldwide (Aiken et al., 2009; Ball et al., 2014; Carryer et al., 2010) and from this work, a variety of nurse staffing strategies have developed over the last 25 years (for example: Griffiths et al., 2016; McKelvie, 2019; The Shelford Group, n.d.). Where dominant priorities speak over solid evidence and patient safety, converting nursing knowledge into objective abstract processes (like acuity and traffic light variance scores), significant and consequential implications arise, which we explicate here.

In a 2014 conference address, Professor Linda Aiken identified that much of the staffing research has been designed to convince policy writers and budget holders of the connection between nurse staffing and patient outcomes. McKelvie (2019) shows that this intention has shaped the nature of much of the research and emerging strategies into quantitative approaches to calculating nurse staffing in standardised measurable forms (such as patient acuity, hours per patient day, ratios), quality indicators (nurse sensitive measures such as falls and infection rates), and fiscal returns (bed days saved, dollars saved), in order to provide evidence shaped by neoliberal priorities for managerial decision-making. In turn, hospital nurses in Aotearoa New Zealand have been taught to take up these quantifying tools and discourses and translate their complex, deeply nuanced and contextual situated intelligence into standardised numerical labour equations, nursing hours, and traffic light colours.

McKelvie (2019) found that there are multiple points in staffing processes where nurses' professional judgement and situated intelligence, has to be translated onto forms, which in turn can be questioned and interrogated for credibility. While some staffing methodologies claim professional judgement is a valued source of intelligence for staffing decision-making (Allen et al., 2023), McKelvie's findings were that nurses' professional judgement and situated intelligence were deemed 'too subjective' and were, in many cases, excluded from counting by managers in employing institutions. Times of austerity amplify this discrediting interrogation, and even override any forms of knowledge-led evidence with blanket decrees of zero spending on staffing and other essentials critical to safe patient care. This results in situations where decision-making is all dollars and no sense; and conveys very clearly that patient safety is something we aspire to, but only when we can afford it. Even in the best of times, nursing's professional expert testimony struggles for sufficient credibility or leverage to counter the dominant ideologies and knowledge hierarchies of the medical and managerial hegemonies.

Case study two: The long overdue transformation of primary healthcare

Webster's (2022) doctoral study revealed that the delivery of healthcare through general practices continued to privilege the ideologies of medicine, new public manage-

ment and business practice. Systems and practices centred on physician-dominated primary care, organised around a medical and business model, to respond to individual patient needs, based on a 15-minute consultation, and focused on diagnosis and interventions. Since the time of data collection in 2017-18, and following the COVID-19 pandemic, the stressors within the primary healthcare sector have considerably amplified. The health sector is reported to be in a workforce crisis, particularly of general practitioners (Royal New Zealand College of General Practitioners, 2021). The growing burden on health services is impacted by worsening socio-economic conditions, considerably increased prevalence of mental health and addiction issues, and fiscal constraints experienced by many non-governmental services. The result is that many general practices are 'closing their books' or at the very least, 'cream-skimming' to limit the number of patients enrolled with social and health complexity (Irurzun-Lopez et al., 2024). The disparity gap for those underserved, marginalised or Indigenous (Māori) is expected to grow.

The general practice model of delivery and funding has been identified as not being *fit for purpose* (HDSR, 2020; Gauld et al., 2019; Goodyear-Smith & Ashton, 2019). The plea for transformation is not new, with a Primary Health Care Strategy (King, 2001) released in 2001. Through this Strategy, the principles of primary healthcare, such as improved population health, coordination of care and continuity of care were promised. Nursing was acknowledged as a workforce which had the potential to expand to deliver on the nation's imperatives to improve access to timely healthcare in community settings and promote health equity (Finlayson et al., 2009). More than twenty years later and the struggles and contradictions continue between the meaning of comprehensive primary healthcare and the extant system of general practice.

The delivery of primary healthcare in Aotearoa New Zealand presents an arena where the privileging of some voices and some ways of knowing are consistently accorded value despite any lack of coherence with the stated strategic objectives. By continuing to privilege medical knowledge, *primary health care strategies* rapidly become informally described as *primary care strategies* and the focus returns relentlessly to the medicalised setting of primary care. Carryer and Adams (2022) note that "Despite medicine's vital but narrow contribution to health outcomes, it is accorded enormous prestige, power and high levels of public recognition and deference. In addition, medicine is also rewarded with high levels of remuneration and assumptions of leadership of healthcare teams" (p. 37e). Meanwhile, nursing continues to work around the gaps created from the hegemonic pursuit of a system that increasingly fails to meet the population's needs.

The current model of primary care has been unable, as yet, to address contemporary issues, including more acute work being delivered in that setting due to reduced secondary care resources; the increased ageing demographic; complex co-morbidities; obesity and lifestyle changes; and growth in prevalence of mental health and addiction (Carryer & Adams, 2017; Downs, 2017). Despite the well sup-

ported knowledge of the connection between social determinants and health outcomes (Jatrana & Crampton, 2021; Oben et al., 2022; Talamaivao et al., 2020), policy and service implementation almost always drive a funding and communication wedge between the two.

There is significant literature demonstrating increased patient satisfaction and improved outcomes when care follows the nurse practitioner (NP) model of practice (Laurant et al., 2018; McMenamin et al., 2023). It is frustrating then, that NPs appear caught up in the restrictive consultation rules of general practice and are frequently not free to deliver care to the full breadth of their model without consequences. This push and pull between the NP model of care and the contradictory expectations of the employer are explored in Webster's (2022) work, showing that the nursing notions of primary healthcare are consistently side-lined and limited to assisting with a medical model of care, as this thesis exemplar from an NP informant shows:

We are supposed to ask the patient "what is your most important concern for today?" and we will address that, and you need to make [another] appointment for the others. How scary is it that that patient had to build up the financial resources to come and see, you with their five problems, and today, sit in front of you, only for you to go, "Sorry, you need to pick one of them." [Webster, 2022, p. 169]

The medicalised expectations of NPs in primary care sit in tension with their training, which prepared them to address population health needs. The same NP informant shows how the NP model of care can work in practice, if they were to go against the business directives:

I had a 29-year-old female come to see me: She had headaches, tummy ache, we started talking, and she's under a lot of stress at home, a lot of financial trouble, starting a new job, a four-year-old at home. And we got to the point where we talked about sexual health, and she said, "Oh no, I'm not on any contraception," so I asked her, "Are you trying for a baby at this stage?" so said, "Oh, please no! That would just add to the stress." She's got all these things going on but never thought of contraception and preventing [pregnancy] putting extra stress on her already stressful life. And she's been seen by quite a few medical staff in the last three weeks, and nobody asked her about that. I was quite concerned. That's what I'm trying to describe, the social, the understanding, and do we have enough time for that? No. So you rush through your consult, and now I need to make sure that she gets contraception, etcetera, then we get to the diagnosis. [Webster, 2022, p. 170]

The care that is most useful to the patient sits alongside or outside of their presenting problem. The NP is acutely aware the model they are expected to work under is not fit for purpose, so they work in the margins of the consultation to deliver true primary healthcare as best they can. This way of working, despite being closely aligned with both the strategic objectives of primary healthcare and culturally appropriate care (Adams & Carryer, 2021), was found not to be supported by the conditions under which NPs work (Webster, 2022). Nursing knowledge as a way of delivering a

primary care consultation is not afforded the same priority as that of bio-medicine, fracturing the connection between the medical problem and the social determinants of health, and thus the goal of primary healthcare.

Case study three: Who knows best how to educate nurse practitioners?

The Report of the Ministerial Task Force on Nursing (1998) laid the groundwork for increasing the scope of registered nurse (RN) practice, including prescribing, and for establishing the role and scope of nurse practitioner (NP). This was in response to anticipated shortages of general practice and specialist doctors; the increasing demand for healthcare; and persisting health disparities facing Māori and other prioritised and underserved communities. Given the introduction of the NP role in the United States in the 1960s, the evidence strongly demonstrated the potential of nursing to improve health outcomes. The Taskforce envisaged NPs spanning the boundaries across general practices and primary healthcare providers, mental health, aged care, into first specialist assessments, acute care services, and respite and rehabilitation services. Nursing laid the foundation for the required legislation and regulation and established the educational pathway (Adams & Carryer, 2023).

Since 1998, there has been a long-running battle to accept the enormous potential of NPs' contributions to health service delivery, and withstand acts of resistance and obfuscation to ensure the establishment and implementation of the NP role continues (Adams, 2017; Officer et al., 2019). Adams' (2017; 2021) doctoral research critically examined the establishment of NPs in rural primary healthcare settings, revealing how the ongoing institutional domination of medicine together with a health policy environment that reflected neoliberal ideology, resulted in the knowledge and practices of NPs to deliver equitable healthcare being, in the main, discounted. At a national level, the evident opportunity for Aotearoa New Zealand to grow and optimise the NP workforce was rendered largely invisible by the institutional ruling relations. Yet at the same time, individual NPs and their organisations continued to develop and promote opportunities, challenging the status quo and innovatively developing models of NP-led care throughout the health system (Adams & Carryer, 2023).

In 2016, a pilot programme to deliver the final year of NP training was jointly delivered by the University of Auckland and Massey University – the Nurse Practitioner Training Programme (NPTP) – and funded by the Ministry of Health. The NPTP is a critical year in which the melding of academic knowledge and clinical skill occurs along with gaining the confidence and capability to practice at the advanced level with full prescriptive authority required to meet NP scope of practice, as regulated by the Nursing Council of New Zealand (NCNZ). The Programme was designed by experienced educators and NPs to reflect educational preparation to a clinical masters level, adequate supervised time as an advanced clinician in practice, and adequate support to complete the necessary requirements (including a portfolio) to apply for registration as a NP on completion of the NPTP year. The latter imperative had been driven by many

NP candidates completing the required university courses, but failing to gain registration as a NP in a timely way, if at all, wasting scarce clinical and educational resources. The pilot NPTP was evaluated as a success (Malatest International, 2018) and a new contract issued by Health New Zealand (then Ministry of Health) to continue delivering NPTP from 2021 to end December 2024, increasing NP candidates from 20 to 50 per year across more universities.

By 2023, nursing began to feel that genuine progress had been made with over 700 NPs filling vital roles and providing critically needed services in a vast range of settings (Adams & Carryer, 2023). Robust international evidence on the safety and efficacy of the NP role (M. Barnett et al., 2022; Laurant et al., 2018; McMenamin et al., 2023) together with Aotearoa New Zealand research (Adams et al., 2024; Kirkman et al., 2018; Komene et al., 2024; Mustafa et al., 2021; Officer et al., 2019) provided the professional knowledge to affirm the value and necessity of developing the NP workforce for the health of communities. The Pae Ora (Healthy Futures) Act (2022) provided the legislative imperative to address health workforce issues and ensure health services advanced health equity. Aligning with this authoritative institutional text, a consortium between the six university schools of nursing had formed to deliver the NPTP, prioritising Māori, Pacific, primary healthcare, mental health and addiction, and other underserved groups and communities. The Consortium publicly advocated for an increase in training places (Pennington, 2022), following demand from both NP candidates and health organisations, and in August 2022, the (then) Minister of Health (Andrew Little) announced more training places for 2023, increasing to 100 in 2024 (Cassie, 2022). For the first time ever, a Health Workforce Plan 2023/24 (Health New Zealand, 2023) reinforced this statement and committed to increasing the number of NP candidates, particularly stipulating the need for growth in Māori, and Pacific, NP numbers. Forming the Consortium was a response to the need to share expertise and experience, use scarce funding wisely, and ensure the availability of NPs as educators, supervisors and mentors, without overly depleting them from the clinical workforce.

In November 2024, with now 805 registered NPs (NCNZ, 2024), 120 NP candidates (expecting to register as NPs in early 2025), and over 140 applications for NPTP, we find ourselves yet again defending our knowledge as nurses, academics and NPs as we await decisions on funding NPTP, and postgraduate nursing education in general, for 2025. In late 2023, during the time the coalition government was being formed, Health New Zealand (HNZ), commissioned Malatest International to undertake a second evaluation of NPTP. The scope was “to evaluate the current NPTP service agreement and the extent to which it supports the development of a NP workforce” (Malatest International, 2024, p. 5). While an array of stakeholders were included to provide

feedback, no NPs were involved in the design, analysis nor report writing; and no evidence, either internationally nor from Aotearoa New Zealand, was included in the evaluation (and not even reference to Malatest International’s previous evaluation in 2018).

The crux of the report (Malatest International, 2024), despite the scope being about the “service agreement”, ultimately challenged how NPs were trained under the NPTP. Malatest International stated:

The NPTP requirement for 500 clinical hours aligns with international practice. Differences in the benefits of the increased clinical hours for NPTP have not been evaluated in an Aotearoa New Zealand context. The difference in clinical hours requirements is a barrier to a nationally consistent NP workforce. (Malatest International, 2024, p. 6).

The recommendation, which followed (and highlighted in a text box) was:

If minimum standards are met by Te Pūkenga then an equitable approach could require inclusion of Te Pūkenga in NPTP funding. (Malatest International, 2024, p. 6).

The above statements do appear ambiguous. On the one hand “500 hours of clinical practice aligns with international practice” and on the other, that delivering NP education as per Te Pūkenga’s model of training is sufficient. Te Pūkenga⁵ (the network of institutes of technology and polytechnics, ITPs) offer fewer study days and just 300 hours of advanced clinical practice hours, which can be further reduced to 150 hours, if the nurse has previously completed a registered nurse prescribing practicum. Less than 5% of all NPs having been trained through Te Pūkenga institutes in the past four years. Yet the Malatest International (2024) report “recommends” what would be a cheaper, minimum standard of NP training. It is not evident from the data provided in the report how this conclusion was reached.

The Malatest Report (2024) was taken up by HNZ funders (the general managers who commissioned the external evaluation) as the authoritative knowledge on the training and education of NPs, with an intent to ensure that HNZ were not “overinvesting” in NP training and how the report’s recommendations could be “incorporated into a new programme” (John Snook, personal communication, 26 June). Adams, as co-lead of the NP workforce programme, experienced this as a ‘line of fault’, a term used in IE (Kearney et al., 2019) where those with the experiential knowledge of NP workforce establishment, education and training was being contested by those in positions of authority within the institution of healthcare. While Te Pūkenga’s model met NCNZ education requirements these standards were outdated, as expressed by the knowledge of NP educators and mentors across the sector (Adams et al., 2022) and

⁵ Note Te Pūkenga is in the process of being disestablished. See Ministry of Education (2024):

Redesign of the vocational education and training system.

their ongoing concern that patient safety was being marginalised. The NCNZ, as the regulator with their primary function, under the Health Practitioner Competence Assurance Act (HPCA) (2003), “to protect the health and safety of members of the public” (NCNZ, n.d., p. para 1) had already announced that they would be completing a review of NP Education Programme Standards in 2025 (a process which has now begun). To counter the Malatest International report’s recommendation, NCNZ wrote to HNZ’s chief nurse (Catherine Byrne, personal communication, July 11, 2024) stating:

“[W]e strongly recommend the NPTP contract continues with the existing requirements including the 500 clinical hours in the Practicum course until such time as the Council has completed the review.”

The healthcare sector and nursing are under extreme pressure at the moment (G. Campbell, 2024; Weston, 2024). NPs, NP educators, and nursing leadership, throughout the sector, know the necessity of high quality, comprehensive and adequately funded education being fundamental to maintaining the capability and capacity of NPs (Ljungbeck et al., 2021). We are in no doubt that our patients and communities would affirm this position. NP services meet the needs of people and communities and, as such, reduce the load on emergency departments and hospital services (McMenamin et al., 2023; Mileski et al., 2020; Savard et al., 2024). While the number of general practitioners continues to decline, with very long wait times and fewer people able to enrol in a general practice, NPs are stepping up to deliver comprehensive primary healthcare, working collaboratively with general practitioner and allied health colleagues. Growing numbers of Māori NPs are demonstrating the opportunity of delivering holistic whānau-centric safe care (Komene et al., 2024) and NPs are increasingly owning and leading general practices keeping the nursing and social justice paradigm central to their practice philosophy (Adams et al., 2024; Delvin et al., 2018).

Given the enormous potential for NPs to deliver comprehensive primary healthcare, mental health and addiction and acute specialist services across Aotearoa New Zealand’s health sector (Adams et al., 2024; Carryer & Adams, 2017), why then does it feel that we are again fighting for the recognition of NPs as advanced healthcare practitioners? The efforts of those NPs innovatively delivering services across communities and client populations to improve health and wellbeing are obscured by those in positions of power who remain beholden to new public management ideals and persisting medical hegemony.

DISCUSSION

Fifty years ago nursing education in Aotearoa New Zealand moved from hospital-based apprenticeship model to the tertiary education sector (Wilkinson, 2023). Within the circles of nursing academia and leadership, here and overseas, a call developed during this time to strengthen nursing’s voice with recourse to hard evidence and become a research-based profession. Nurses were told, and told themselves, that if they just had evidence constructed in

the form of hard data their voices would be heard and their knowledge taken seriously. Perhaps they recognised that hard data, as a way of knowing, would speak more directly to those who controlled funding, wrote policy, and designed systems. Since then, significant volumes of nursing research have been provided by nurse academics and clinicians who have conducted and published research to answer multiple questions related to nursing and health service delivery. Despite the compelling nature of this evidence supporting patient safety, nurse staffing, patient-centred care and the value and contribution of extended nursing roles, the dominant priorities of neoliberal policy environments, general managerialism, and persisting medical hegemony speak over this evidence and continue to marginalise the voice of nursing (P. Barnett & Bagshaw, 2020; Freeman & Baum, 2024; Gauld, 2016; Griffith & Smith, 2014; MacNaughton & Ahmed, 2023).

The three case studies presented draw on institutional ethnography as an approach to explicate how the voice of nursing is superseded and constrained within the institution of healthcare. The area of hospital staffing (Case Study One) is one where vast volumes of data have been produced across multiple settings and countries (Aiken, 2024; Aiken et al., 2021; Kane et al., 2007; McHugh et al., 2021). This extensive and compelling multi-million dollar research has not been sufficient on its own to drive change in policy and budgeting arenas (Aiken, 2024, speaking at NZNO conference on nurse to patient safe staffing ratios). Instead, nurses have had to resort to industrial and legislative action, and continue to fight to hold the ground that has been gained. The research in Case Study One adds the notion of situated intelligence as a clear epistemology that is rarely accorded any regard at all (McKelvie, 2019). As this case study has shown there is still no certainty that registered nurse staffing will be designed against best evidence for patient safety rather than with attention to ensuring the viability of the *budget bottom line*. It is, furthermore, a bottom line of the moment and not a bottom line that accommodates the adverse events and readmissions and long-term consequences when patient safety has been compromised. The Minister-appointed commissioner (in July 2024) has clearly articulated the direction of travel required to recoup a perceived overspend of NZ\$1.4 billion health sector dollars (G. Campbell, 2024). As we went to press the possibility of pausing the CCDM FTE calculations was being considered, “while we [HNZ] undertake quality improvement processes,” stated Mark Sheppard, spokesperson for HNZ (Hill, 2024). Of course, tools like the FTE calculation should be regularly scrutinised as data and knowledge develops. However, at a time when cost containment and rationalising FTE are central to HNZ’s agenda, there is concern among nurses that pausing could have consequential impact on patient safety and the safe staffing agenda (Hill, 2024). While no one is certain how big nor how far the ripples of such actions will extend, it is certain that everyone in the health sector will feel them, including patients, whānau and communities.

Case Study Two attends to the long expressed global need to move health systems from a central focus on acute

care towards concerted attention to prevention of illness and morbidity and universal access to healthcare (Downs, 2017; Gauld, 2016; Goodyear-Smith & Ashton, 2019; HDSR, 2020). Nursing's philosophy is grounded in the imperative of health promotion and social justice (Adams et al., 2024; Delvin et al., 2018; Dillard-Wright & Shields-Haas, 2021), but nurses still argue from the sidelines of political and bureaucratic decision-making (Davis et al., 2021; Manning et al., 2024; McDonald, 2022). The incorporation of a strong nursing background in service leadership and service delivery supports a greater focus on genuine primary healthcare and a stronger acknowledgment of Te Ao Māori (a Māori world view) to promote patient and whānau safety and wellbeing (Davis et al., 2021; Komene et al., 2024). Decision-making is fragmented, and strategies rarely move beyond the so-called *high level*. Decisions are made by bureaucrats about where they will source evidence and whose consultations will count. Case Study Two demonstrates not so much a failure to listen to individual nursing advice but more a complete lack of awareness of ways of knowing or understanding that fall outside current hegemony and sit within new public management ideology (P. Barnett & Bagshaw, 2020; Griffith & Smith, 2014). The nursing understanding of primary *healthcare* as a broad lifespan and pre-emptive wellness focus, as aligned with World Health Organization expectations to achieve universal health coverage (D. Stewart et al., 2024), is rarely accorded primacy over the more medicalised attention to *primary care* as first contact medical care.

Data supporting the need for and contribution of NPs (Case Study Three) has steadily increased in volume and value over at least 40 years. In summary, the data has supported the safety of NP substitution for medical practitioners, the cost efficacy of using NPs, reduced hospitalisations, and high levels of consumer satisfaction when NPs provide more care (M. Barnett et al., 2022; Laurant et al., 2018; McMenamin et al., 2023). The wider distribution of nursing staff and NP candidates in rural areas and small towns also offers critical support to declining access to care for those communities (Adams & Carryer, 2020). Most importantly research has suggested the importance of using NPs as a vehicle for transforming the highly medicalised focus of health service delivery (Adams et al., 2024; Carryer & Adams, 2017; Delvin et al., 2018; Porat-Dahlerbruch et al., 2022). Nursing has worked hard to achieve the legislative and educational framework in which NPs can be produced and can flourish in Aotearoa New Zealand (Adams & Car-

ryer, 2023). The collaboration for the delivery of NPTP, led by NPs, through a consortium of six universities working in partnership with nursing sector leaders and national nurse leaders and advisors, combines clinical, academic, work-force and policy expertise. The result is a nationally coordinated NP training programme cognisant of the availability of fiscal and human resource together with the imperative for high quality training to ensure safety in practice. Yet, as Case Study Three shows, there is ongoing disregard for this knowing with an intent to source knowledge from elsewhere, privileging a general managerial lens and being governed by cost-saving imperatives.

Much nursing literature has described the struggle nursing has had to be at the policy making table and around the tables of organisational leadership (Davis et al., 2021; Manning et al., 2024; McDonald, 2022). We have come to the sobering realisation that regardless of our research, regardless of our presence or otherwise, our advice and guidance is simply neither heard nor regarded as important. We categorically dispute the hegemonic discourses and practices that subordinate the credibility of nursing knowledge and relegate it to a lower position in knowledge hierarchies. Having spent decades in the endeavour of generating our knowledge in our own forms, as well as that required of hegemonic power holders, we seriously question whether it will ever be possible for nursing knowledge to be granted different credibility within knowledge hierarchies. We posit that this is less to do with the ability of nursing to produce the exquisitely detailed knowledge required for service and patient care design and policy, and more to do with the inabilities and inadequacies of those who could and should be listening.

Conflict of interest

SA and RM are on the editorial board of Nursing Praxis in Aotearoa New Zealand.

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